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ABSTRACT

As the Acquired Immune Deficiency Syndrome (AIDS) epidemic escalates, the need for primary prevention programs to disseminate information has become more important than ever. This research is an analysis of all calls received by an AIDS hotline in central Massachusetts over an 8-month period. Of the 387 calls received, 55% were from males. The majority of callers were in their 20s (42%) or 30s (22%), with 5% of calls coming from adolescents. Among risk behaviors, 9% of callers identified themselves as homosexual men, 3% identified themselves as bisexual men, and 7% identified themselves as intravenous drug users. Forty-five percent called to ask questions about what constituted high-risk behavior. Only 2% of callers were already diagnosed as human immunodeficiency virus (HIV) infected. Forty-three percent of callers wanted information about HIV testing, while only 17% were interested in safer sex information. Adolescents tended to be more interested in obtaining safer sex information. A highly significant gender difference in presenting problems was noted. Men called primarily because they were concerned about their own health and possibility of infection, while women called primarily because they were concerned about family members, partners, or friends. These hotline data point out the need for further education and community outreach. (NB)

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AN AIDS HOTLINE: PRIMARY PREVENTION IN THE COMMUNITY

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ABSTRACT

As the AIDS epidemic escalates, the need for primary prevention programs to disseminate information has become more important than ever. This research is an analysis of all calls received by an AIDS hotline in central Massachusetts over an eight month period. Caller demographics and types of presenting problems of callers are reported. The needs of adolescents, the desire of callers for HIV testing rather than safer sex information, and gender differences in concerns about AIDS are discussed. Increased education and outreach funding is advocated.

In the second decade of the AIDS epidemic, no cure or preventive vaccine for HIV Spectrum Disease has yet been discovered. Our former Surgeon General Koop (1986) has stated that education is the best preventive tool at our disposal currently.

Education through telephone hotlines is a form of primary and secondary prevention which has been used successfully in dealing with suicide, physical and sexual abuse, and alcoholism (Hornblow, 1986), as well as eating disorders (Burket & Hodgin,1989) and physical illness (Tekavcic-Grad et al, 1988). Analysis of the calls received by hotlines has yielded valuable descriptive data regarding incidence and types of presenting problems as well as information regarding the callers. Pierce & Pierce (1985) reported important descriptive information about victims and perpetrators of sexual abuse. Burket & Hodgin's analysis of the eating disorders hotline provided demographics regarding types of callers and their presenting problems. Cross-cultural studies have compared the caller profiles and problems of hotlines in the United States and several European countries (Tekavcic-Grad et al, 1988; Wolfersdorf et al, 1989).

Most community AIDS agencies have hotlines to provide information and referral to callers who have a

variety of concerns about AIDS. In Massachusetts, the first such hotline was provided by the AIDS Action Committee in Boston in 1982, under the direction of Larry Kessler. In central Massachusetts, AIDS Project Worcester formally commenced a hotline service in January 1988. The present study is an analysis of the hotline calls received in the first eight months of 1988.

PROCEDURES

The AIDS Project Worcester (APW) hotline was staffed by over 30 volunteers who worked four-hour shifts to operate the hotline for 12 hours a day, six days a week. Volunteers were recruited through newspaper advertisements, and the appearance of two staff members on a local radio talk show.. All volunteers were screened by the APW staff to determine their motivation and capabilities, and then trained by a team of health care and mental health professionals. These trainers included a supervisor from a local crisis hotline, the director of the AIDS Action Committee hotline, a drug counselor, a speaker from a Gay Rights organization, an RN from the Visiting Nurses' Association, an AIDS educator, a clinical social worker, and a representative from the public health department. Volunteers attended three six-hour training sessions, which provided information concerning all aspects of AIDS

Spectrum Disease as well as procedure to be used in answering hotline calls and referring the caller to various service agencies. Role-play, simulation and small-group discussions were used. Packets of information including referral sources and telephone numbers were provided to each volunteer. Hotline volunteers were individually supervised for the first two weeks that they answered hotline calls. After that, a supervisor or professional staff person was available to answer questions or help the volunteer in problem-solving. In addition, staff persons were ready to assist volunteers who had affective discord resulting from callers' presenting issues of illness, fear, pain, loss, anger and grief.

Each volunteer kept a tally sheet and recorded information as each call was answered. The record included information regarding the age, gender, marital status, sexual orientation, risk behavior, health status, and types of presenting problems of each caller. The tally sheet was developed by the AIDS Action Committee of Boston, and has been used by their hotline volunteers as well. Volunteers were instructed to obtain as much information as possible without being intrusive, and to inform the caller that such data collection was being done to determine the needs of the community. All tally sheets were turned in to the

supervisor or staff person at the end of the four-hour shift, and were arranged in chronological order. In the first eight months of operation, 387 calls were logged by the hotline volunteers.

RESULTS

Of the 387 calls, 55% of the callers were male, while 45% were female. In terms of age groups, 5% were adolescents, 42% were in their 20s, 22% were in their 30s, 7% were in their 40s, and 15% were over 50. Volunteers did not obtain age information from 27% of callers.

Among risk behaviors, 9% of callers identified themselves as gay men, 3% identified themselves as bisexual men, 7% reported that they were IV drug users, .5% stated they were hemophiliacs, 1% identified themselves as sex workers (prostitutes or hustlers), 3% reported that they had sexual contact with a sex worker,and 1% stated that they knew they had engaged in other types of high risk behavior. Forty-five percent called to ask questions about what constituted high-risk behavior, because they were not sure if they were in danger of contracting the virus.

Only 2% of callers were already diagnosed as HIV infected, 1% had symptoms of ARC, and 1% had AIDS opportunistic infections or cancers.

Analysis of presenting problems revealed some striking patterns. Overall, 43% of callers wanted information about HIV testing, but only 17% were interested in safer sex information. Tables 1 and 2 indicate the analysis of calls requesting HIV testing information as opposed to safer sex information by age and risk behavior.

Insert Tables 1 and 2 about here.

Table 1 shows that all age groups except for adolescents and those over 50 were more interested in HIV testing than safer sex information, often by a 2:1 margin. Analysis by risk behavior revealed the same results, except in the case of bisexual persons, who called just as frequently for safer sex information as HIV testing information. Any caller may have asked about HIV testing, safer sex, both, or neither, so percentages reflect the proportion of callers from each group who inquired about each of these issues.

The media have focused on the spreading of infection by gay and bisexual men, who, because of internalized and societal homophobia, have married and infected their spouses (e.g. The AIDS Quarterly, Fall 1989). Table 3 supports the notion that among this sample this is not a common occurrence, as only 3% of gay male callers and 12%

of bisexual male callers were married to women. However, the tally sheet contains no information about gay and bisexual men having sex with women who are not their spouses. It is possible that the incidence of infection is greater outside of marriage in this sample.

Insert Table 3 about here.

Finally, a highly significant gender difference in presenting problems was noted. Table 4 shows that men called the hotline primarily because they were concerned about their own health and possibility of infection, while women called primarily because they were concerned that a family member, partner or friend was infected or in danger of being infected.

Insert Table 4 about here.

DISCUSSION

The data show that while only 5% of callers were adolescents, when they did call it was frequently to obtain safer sex information. This suggests first, that many teenagers in the general population are unaware of the danger of infection, and second, that those who are aware are not receiving in school the information they need to prevent infection.

As Cheney (1989) points out, adolescents are at high risk for contracting the virus, and the number of HIV infected adolescents is currently proliferating. Since early 1988 many schools have begun to do AIDS education, but many such programs stress abstinence without fully discussing methods to prevent infection for those adolescents who are already sexually active or using IV drugs.

The results also indicate that many more callers, regardless of age or risk behavior, were interested in HIV testing instead of safer sex information. This may have occurred because people were worried that they might already be infected, and so their first priority was to find out if they were seropositive. Redding, Rossi, Velicer & Prochaska (1989) have reported that 44% of sexually active college students indicated on a survey that they had no intention of adopting safer sex practices to reduce the risk of HIV infection. The researchers interpret this finding in terms of a stages of change model and view such an attitude as an example of the first stage, Precontemplation, i.e. denying the need for behavioral change. They advocate health campaigns focusing on the personal vulnerability of individuals in contracting the virus. Hopefully, with pre- and post- HIV test counseling, people will begin to see the importance of using safer sex techniques.

Few of the gay or bisexual callers were married, and among the heterosexual callers, the vast majority were also unmarried (Table 3). Perhaps unmarried heterosexuals perceive themselves at more risk for contracting HIV than do their married counterparts, because of a higher number of sexual contacts.

The striking gender difference in presenting problems may be attributable to several factors. Many more men than women called the hotline to express concern that they might be infected. It is possible that men in the late 1980s in central Massachusetts might be part of the first wave of infection, i.e., gay and bisexual men might be likely to engage in unprotected receptive anal sex, or men might share IV drug apparatus without cleansing it with bleach solution. However, the female sexual partners of these men could rightly be just as concerned about the possibility of infection and the need for HIV testing, yet the percentage of women who called to express concern about their own welfare was significantly lower than the percentage of men who called with concerns about self. In addition, this hypothesis does not explain the fact that many more women than men called to express concern about family members, partners or friends, indicating that even if men were more likely to become infected in the late 1980s, those men's <u>female</u>, rather than <u>male</u>, family

members, partners or friends were much more likely to call the hotline to request information needed to help the loved one.

Rather, the differential socialization of males and females in our society is a more plausible explanation of why men's concerns were self-directed while women's were other-directed. In our society, boys learn to be independent, self-reliant, and impersonal, while girls learn to be nurturing, warm, expressive, and concerned for the welfare of others (Rice, 1990). As Eagly (1990) asserts, the current sex difference literature indicates that women display many more altruistic pro-social behaviors than men do. Women show concern for other people and provide interpersonal support and helping behaviors to a greater degree than do men. In a study by Merrill, Laux and Thornby (1989) women medical students and undergraduates had more benevolence toward people with AIDS and less fear of infection than did their male counterparts.

These attitudes and behaviors of women can be seen as the product of learning which may be accomplished through the development of cognitive gender schemas (Jacklin, 1989) whereby children develop a concept of how males and females behave, think, and feel. This concept is developed

through processing information from the environment. While traditional sex-role boundaries are not as rigidly defined as they once were in America, the current literature still shows that we train individuals from infancy how to behave in a culturally defined masculine or feminine way.

Thus, it is possible that most men callers were concerned about themselves, while most women callers were concerned about others because women have been socialized since infancy to be caring and nurturing of other people, while men have been socialized to be self-reliant and independent. The same pattern of results was seen in an attitudes toward suicide survey completed by over 1,100 college students (Wellman & Wellman, 1986).Women were more receptive, sensitive and willing to help suicidal peers than were men. These results were interpreted in terms of sex-role socialization.

These hotline data point out the need for further education and community outreach. Community AIDS agencies have been in the forefront of educational, outreach, client advocacy and support services. In addition, schools need to enlist professional and parental support to provide AIDS education in the context of decision-making and problem-solving skill development and personal growth enhancement, so that adolescents will be better informed and able to make appropriate personal decisions regarding

high-risk behavior. In the 1990s, vigorous governmental support should be forthcoming for community outreach and prevention,particularly to empower those people who are currently most vulnerable to HIV infection.

TABLE 1

AGE, HIV TESTING AND SAFER SEX INFORMATION

AGE GROUP	PERCENT REQUESTING HIV TESTING INFORMATION	PERCENT REQUESTING SAFER SEX INFORMATION
15-20	30%	40%
N	6	8
21-25	42%	17%
N	30	12
26-30	53%	18%
N	50	17
31-35	53%	25%
N	32	15
36-40	25%	20%
N	6	5
41-50	60%	10%
N	6	1
50+	0%	15%
N	0	1

TABLE 2

RISK BEHAVIOR, HIV TESTING AND SAFER SEX INFORMATION

RISK BEHAVIOR	PERCENT REQUESTING HIV TEST INFORMATION	PERCENT REQUESTING SAFER SEX INFORMATION
Gay	52%	33%
N	19	12
Bisexual	53%	53%
N	7	7
IV Drug User	60%	21%
N	17	6
Sex Worker	66%	0%
N	2	0
Sex Worker Contact	54%	36%
N	6	4

TABLE 3

SEXUAL ORIENTATION AND MARITAL STATUS

	SINGLE	MARRIED
GAY	97%	3%
N	38	1
LESBIAN	100%	0%
N	4	0
BISEXUAL	88%	12%
N	15	2
HETEROSEXUAL	80%	20%
N	130	33

$X^2 = 8.3$ df=3 p=.04

TABLE 4

GENDER DIFFERENCES IN PRESENTING CONCERNS

	MALES	FEMALES
UNDIAGNOSED WORRIED		
TOTAL %	41%	8%
ROW %	83%	17%
N	60	12
DIAGNOSED INFECTED		
TOTAL %	8%	0%
ROW %	100%	0%
N	12	0
WORRIED ABOUT LOVED ONE		
TOTAL %	10%	27%
ROW %	27%	73%
N	15	40
HEALTH CARE PROVIDER		
TOTAL %	1%	4%
ROW %	14%	86%
N	1	6

$X^2 = 55.09$ df=3 p=.0000 N=146

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